TO THE MISSISSIPPI WORKERS' COMPENSATION COMMISSION:

Employer _____

Address _____

Locations Covered _____

Nature of Business _____

This is to certify that the Workers' Compensation policy of the employer described herein has been:

Issued _____ Renewed _____ Canceled _____

Policy Number _____ Effective _____ Expires _____

Reason for cancellation _____

_____

Compulsory risk _____ Exempted Risk _____

Carrier: _____ Issuing office _____

Revised 7/15/49 Form A-24

TO THE MISSISSIPPI WORKERS' COMPENSATION COMMISSION:

Employer _____

Address _____

Locations Covered _____

Nature of Business _____

This is to certify that the Workers' Compensation policy of the employer described herein has been:

Issued _____ Renewed _____ Canceled _____

Policy Number _____ Effective _____ Expires _____

Reason for cancellation _____

_____

Compulsory risk _____ Exempted Risk _____

Carrier: _____ Issuing office _____

Revised 7/15/49 Form A-24

TO THE MISSISSIPPI WORKERS' COMPENSATION COMMISSION:

Employer _____

Address _____

Locations Covered _____

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This is to certify that the Workers' Compensation policy of the employer described herein has been:

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Revised 7/15/49 Form A-24